

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

37862

STATE FILE NUMBER

FILED NOV 6 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9961

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Christian Hospt.</u> Length of stay in lb _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u> c. CITY OR TOWN <u>Wellston</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>1136 Sutter</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle _____ Last <u>Miller</u>				4. DATE OF DEATH Month <u>10</u> Day <u>23</u> Year <u>57</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-7-1868</u>		9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Glaser</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Glass</u>		11. BIRTHPLACE (City and state or country) <u>Ill.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unk Miller</u>						14. MOTHER'S MAIDEN NAME <u>Unk</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Joseph Miller</u> Address <u>1136 Sutter Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>Chr. Interstitial nephritis</u> (Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>chronic interstitial nephritis</u> DUE TO (c) <u>Arteriosclerosis</u> <u>arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>446x</u>								
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month _____ Day _____ Year _____			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) _____			20f. CITY, TOWN, OR LOCATION _____			COUNTY _____			STATE _____		
21. I attended the deceased from <u>10-16-57</u> to <u>10-23-57</u> and last saw her alive on <u>10-22-57</u> Death occurred at <u>5:45 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <u>N.J. Fuchs</u> (Degree or title) <u>M.D.</u>						22b. ADDRESS <u>608 Kingsland</u>			22c. DATE SIGNED <u>10-24-57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>10-25-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>			23d. LOCATION (City, town, or county) <u>St. Louis, Mo.</u> (State) _____			
24. FUNERAL DIRECTOR <u>J.W. Clark</u> ADDRESS <u>F.H. 1125 Hodiemont</u>						25. DATE RECD. BY LOCAL REG. <u>OCT 24 57</u>			26. REGISTRAR'S SIGNATURE <u>Earl Smith</u>		

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

OFFICE OF THE STATE EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No. 26.

P. O. Address 11257/22

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.